Beginning Billing Workshop Waiver

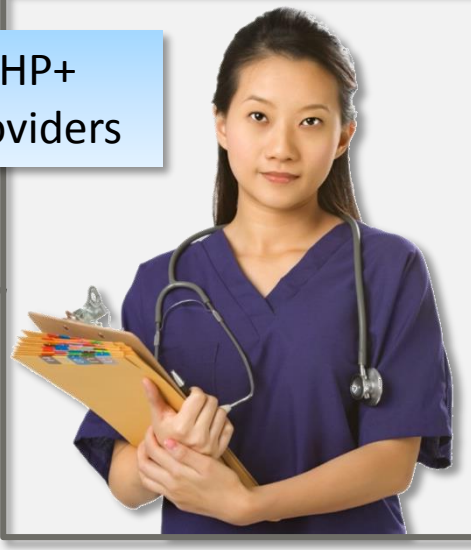
Colorado Medicaid
2014

Centers for Medicare & Medicaid Services

Department of Health Care Policy and Financing

Medicaid

Medicaid/CHP+ Medical Providers



Xerox State Healthcare

Training Objectives

- Billing Pre-Requisites
  - National Provider Identifier (NPI)
    - What it is and how to obtain one
  - Eligibility
    - How to verify
    - Know the different types
- Billing Basics
  - How to ensure your claims are timely
  - When to use the CO 1500 paper claim form
  - How to bill when other payers are involved

What is an NPI?

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
  - Regardless of job/location changes

What is an NPI?

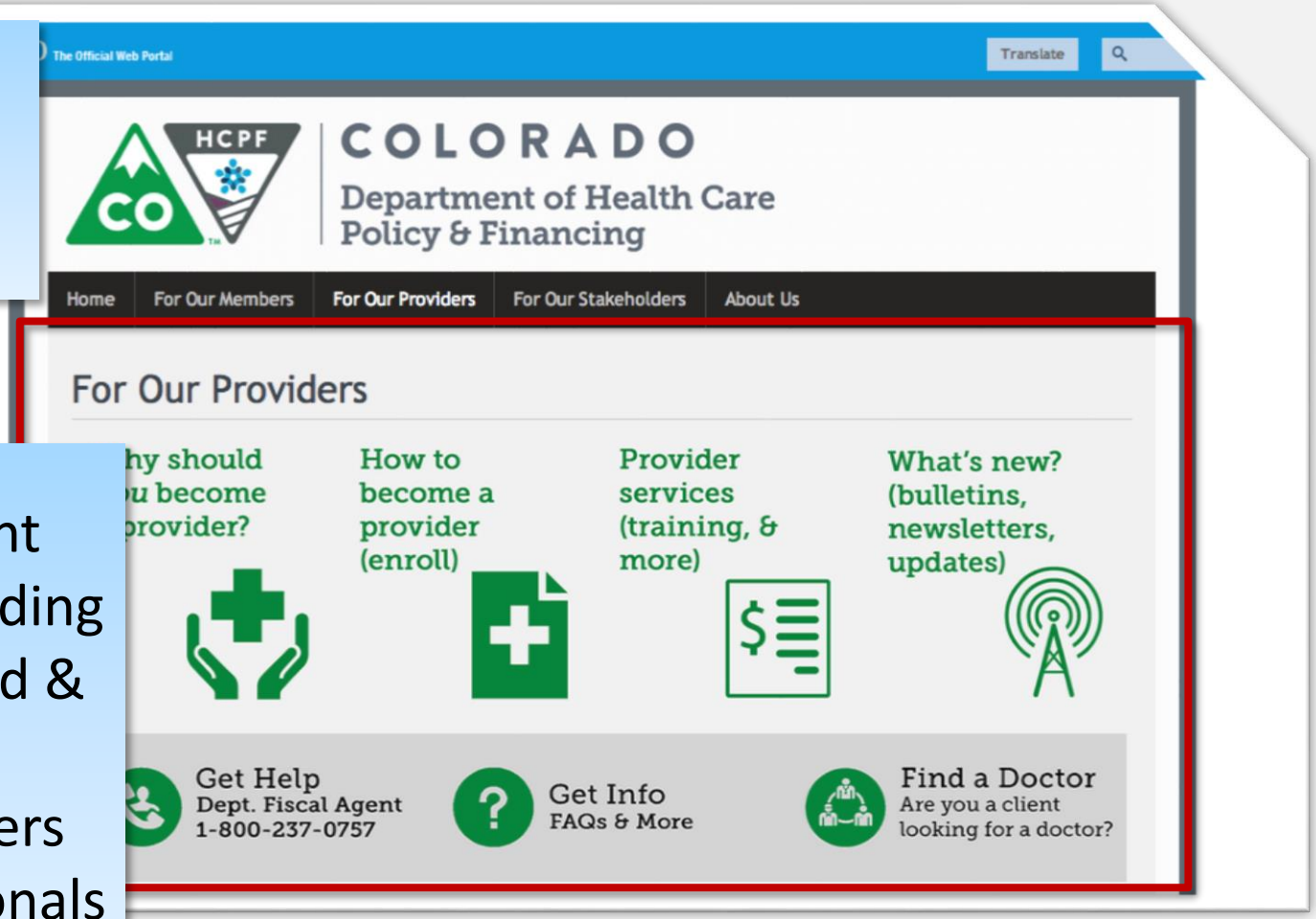
- How to Obtain & Learn Additional Information:
  - CMS web page (paper copy)-
    - www.dms.hhs.gov/nationalproldentstand/
  - National Plan and Provider Enumeration System (NPPES)-
    - www.nppes.cms.hhs.gov
  - Enumerator-
    - 1-800-456-3203
    - 1-800-692-2326 TTY
  - **Waiver Provider currently <u>do not</u> require a NPI**

NEW! Department Website

NEW! Provider Home Page

Find what you need here

Contains important information regarding Colorado Medicaid & other topics of interest to providers & billing professionals



Provider Enrollment

Question:

What does Provider Enrollment do?

Answer:

Enrolls providers into the Colorado Medical Assistance Program, *not* members

Question:

Who needs to enroll?

Answer:

Everyone who provides services for Medical Assistance Program members

Billing Provider Number

Billing Provider

- Entity being reimbursed for service

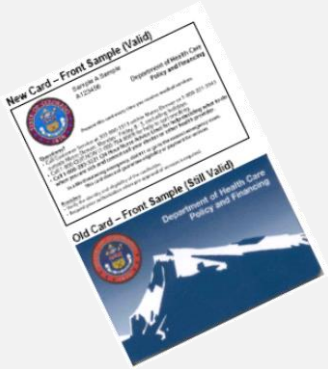
Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
- Ways to verify eligibility:

Web Portal

Fax Back
1-800-493-0920

CMERS/AVRS
1-800-237-0757

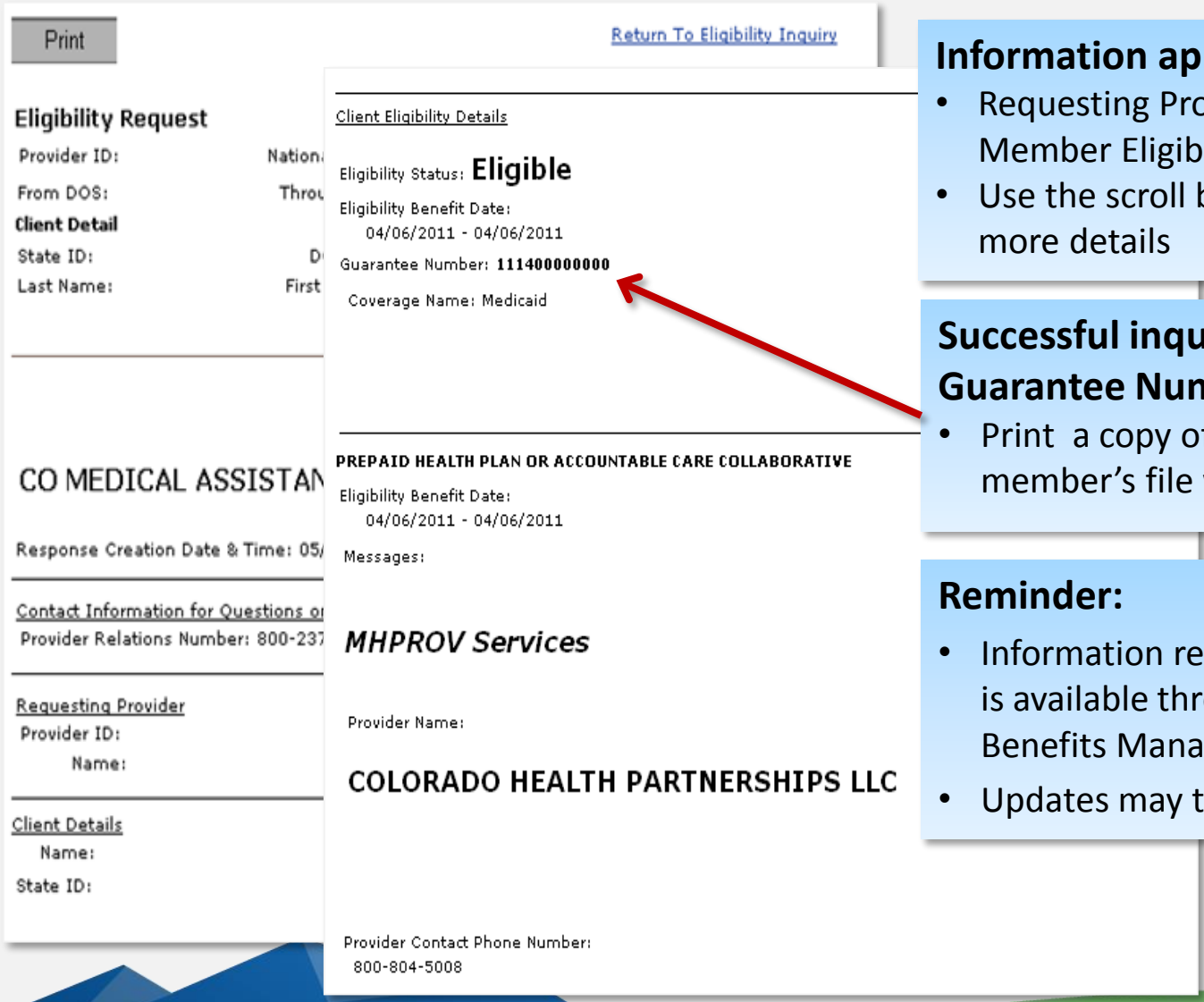


Medicaid ID Card with Switch Vendor

Eligibility Response Information

- Eligibility Dates
- Co-Pay Information
- Third Party Liability (TPL)
- Prepaid Health Plan
- Medicare
- Special Eligibility
- BHO
- Guarantee Number

Eligibility Request Response (271)



Information appears in sections:

- Requesting Provider, Member Details, Member Eligibility Details, etc.
- Use the scroll bar to the right to view more details

Successful inquiry notes a Guarantee Number:

- Print a copy of the response for the member's file when necessary

Reminder:

- Information received is based on what is available through the Colorado Benefits Management System (CBMS)
- Updates may take up to 72 hours

Medicaid Identification Cards

- Both cards are valid
- Identification Card does not guarantee eligibility


Sample A Sample
A123456

Department of Health Care Policy and Financing

Present this card every time you receive medical services.

Questions?
- Call Customer Service at 303-866-3513 within Metro Denver or 1-800-221-3943 outside Metro Denver, Monday - Friday, 8 - 5, excluding holidays.
- Call 1-800-QUIT.NOW (1-800-784-8669) for help to quit smoking.
- **Call 1-800-283-3221 (24 Hour Nurse Advice Line) for help deciding what to do when you are sick and cannot call your doctor or other health provider.**

In a life threatening emergency, dial 911 or go to the nearest emergency room.
This card does not guarantee eligibility or payment for services

Providers:
- Verify the identity and eligibility of the cardholder.
- Request prior authorization when pre-approval of services is required.

Billing Overview

- Record Retention
- Claim submission
- Prior Authorization Requests (PARs)
- Timely filing
- Extensions for timely filing

Record Retention

- Providers must:
  - Maintain records for at least 6 years
  - Longer if required by:
    - Regulation
    - Specific contract between provider & Colorado Medical Assistance Program
  - Furnish information upon request about payments claimed for Colorado Medical Assistance Program services

Record Retention

- Medical records must:
  - Substantiate submitted claim information
  - Be signed & dated by person ordering & providing the service
    - Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements

Submitting Claims

- Methods to submit:
  - Electronically through **Web Portal**
  - Electronically using **Batch Vendor**, **Clearinghouse**, or **Billing Agent**
  - **Paper** only when
    - Pre-approved (consistently submits less than 5 per month)
    - Claims require attachments

Payment Processing Schedule

Mon.

Tue.

Wed.

Thur.

Fri.

Sat.

Payment information is transmitted to the State's financial system

Accounting processes **E**lectronic **F**unds **T**ransfers (EFT) & checks

EFT payments deposited to provider accounts

Paper remittance statements & checks dropped in outgoing mail

Weekly claim submission cutoff

Fiscal Agent processes submitted claims & creates PCR

Electronic Funds Transfer (EFT)

- Several Advantages:
  - Free!
  - No postal service delays
  - Automatic deposits every Friday
  - Safest, fastest & easiest way to receive payments
  - Located in Provider Services Forms section on Department website

Waiver PARs

CCB →

Adult w/ DHS Waivers

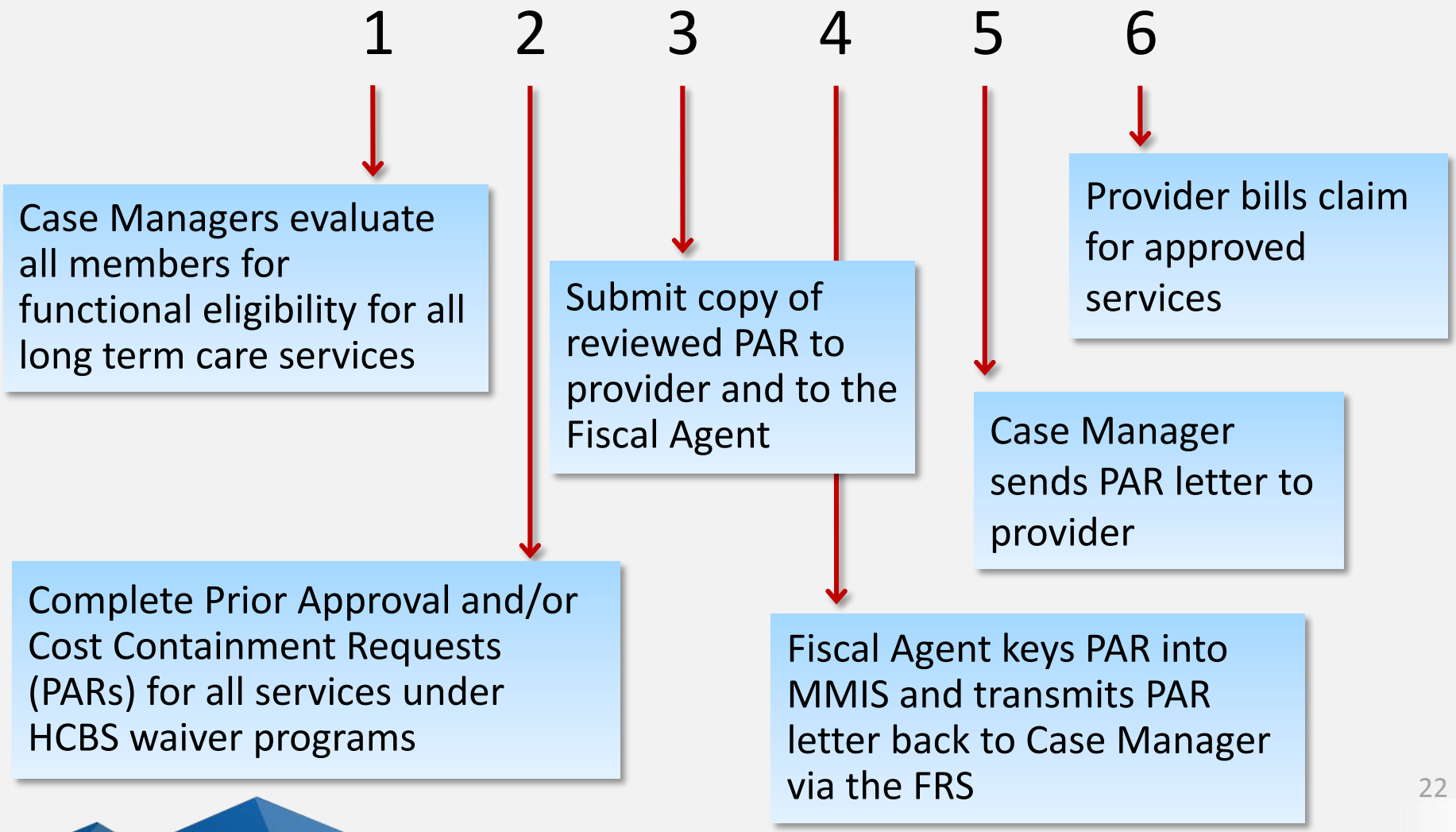
- Supported Living Services (SLS)
- Developmentally Disabled (DD)
- Children's Extensive Support (CES)
- Day Habilitation Services and Support (DHSS)

CMA / SEP →

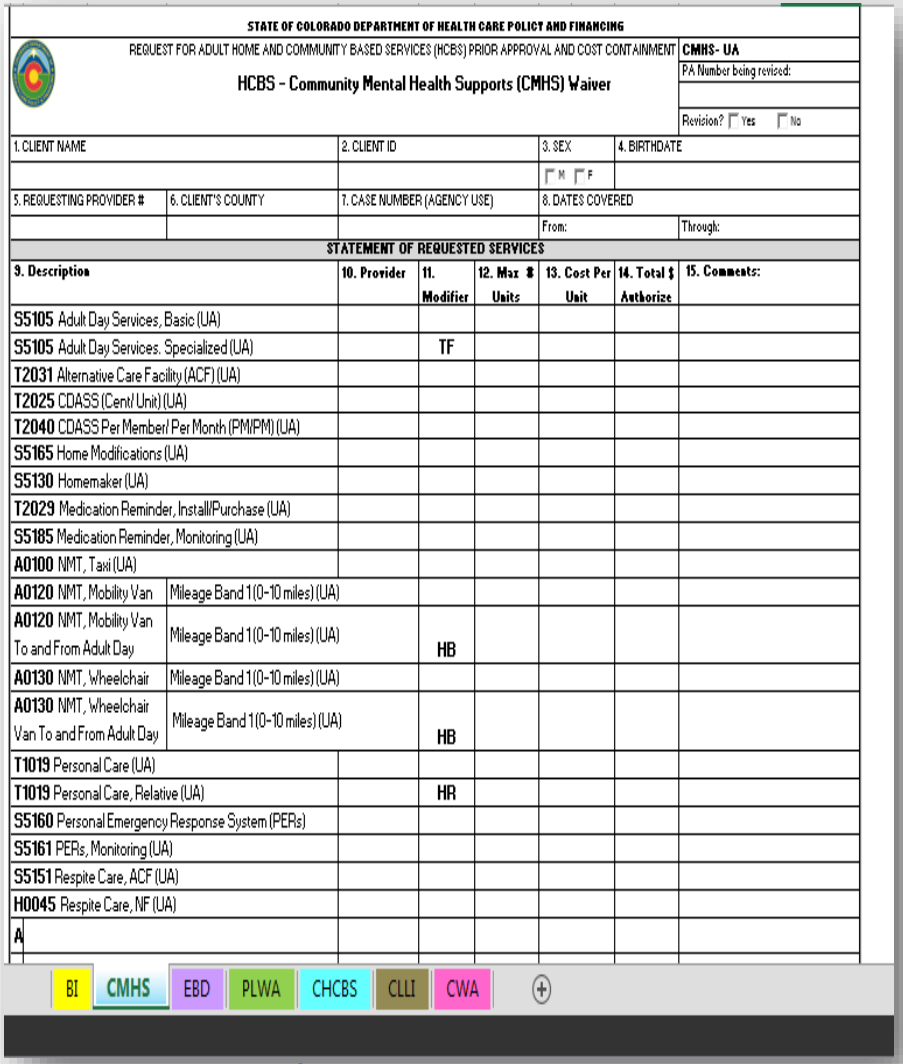
Adult with or without HCPF Waivers

- Elderly Blind and Disabled (EBD)
- Community Mental Health Services (CMHS)
- Brain Injury (BI)
- Spinal Cord Injury (SCI)
- Children with Life Limiting Illness (CLLI)
- Children With Autism (CWA)
- Children's Home Community Based Services (CHCBS)

Prior Authorization Flow



Waiver Prior Authorization Form



STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT — CMHS- UA

HCBS - Community Mental Health Supports (CMHS) Waiver

PA Number being revised:

Revision? ☐ Yes ☐ No

1. CLIENT NAME		2. CLIENT ID	3. SEX	4. BIRTHDATE
			☐ M ☐ F	
5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED	
			From:	Through:

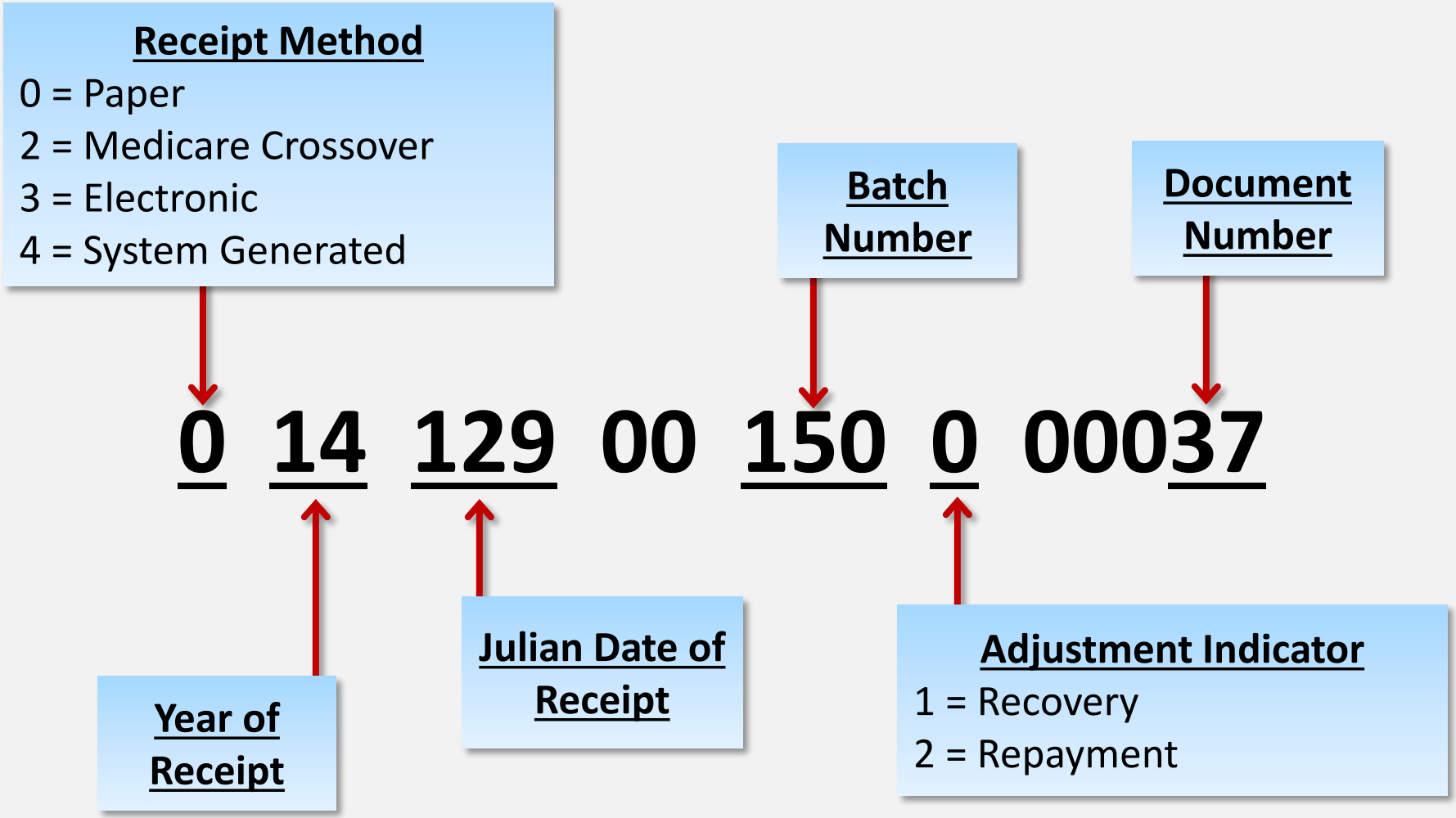
STATEMENT OF REQUESTED SERVICES

9. Description		10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorize	15. Comments:
S5105 Adult Day Services, Basic (UA)							
S5105 Adult Day Services, Specialized (UA)			TF				
T2031 Alternative Care Facility (ACF) (UA)							
T2025 CDASS (Cent/ Unit) (UA)							
T2040 CDASS Per Member/ Per Month (PM/PM) (UA)							
S5165 Home Modifications (UA)							
S5130 Homemaker (UA)							
T2029 Medication Reminder, Install/Purchase (UA)							
S5185 Medication Reminder, Monitoring (UA)							
A0100 NMT, Taxi (UA)							
A0120 NMT, Mobility Van	Mileage Band 1 (0-10 miles) (UA)						
A0120 NMT, Mobility Van To and From Adult Day	Mileage Band 1 (0-10 miles) (UA)		HB				
A0130 NMT, Wheelchair	Mileage Band 1 (0-10 miles) (UA)						
A0130 NMT, Wheelchair Van To and From Adult Day	Mileage Band 1 (0-10 miles) (UA)		HB				
T1019 Personal Care (UA)							
T1019 Personal Care, Relative (UA)			HR				
S5160 Personal Emergency Response System (PERs)							
S5161 PERs, Monitoring (UA)							
S5151 Respite Care, ACF (UA)							
H0045 Respite Care, NF (UA)							
A							

BI | CMHS | EBD | PLWA | CHCBS | CLLI | CWA

- Find Adult HCBS Prior Approval and Cost Containment workbook for Waiver programs on the Department's website
  - colorado.gov/hcpf/provider-forms

Transaction Control Number



Timely Filing

- 120 days from Date of Service (DOS)
  - Determined by date of receipt, not postmark
  - PARs are not proof of timely filing
  - Certified mail is not proof of timely filing
  - Example – DOS January 1, 20XX:
    - Julian Date: 1
    - Add: 120
    - Julian Date = 121
    - Timely Filing = Day 121 (May 1st)

Timely Filing

From "through" DOS

- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

From DOS

- FQHC Separately Billed and additional Services

From delivery date

- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
  - Service Date = Delivery Date

Documentation for Timely Filing

- 60 days from date on:
  - Provider Claim Report (PCR) Denial
  - Rejected or Returned Claim
  - Use delay reason codes on 837P transaction
  - Keep supporting documentation
- Paper Claims
  - CO 1500- Note the Late Bill Override Date (LBOD) & the date of the last adverse action in the Remarks

Timely Filing Extensions

- Extensions may be allowed when:
  - Commercial insurance has yet to pay/deny
  - Delayed member eligibility notification
    - Delayed Eligibility Notification Form
  - Backdated eligibility
    - Load letter from county

Extensions – **Commercial Insurance**

- 365 days from DOS
- 60 days from payment/denial date
- When nearing the 365 day cut-off:
  - File claim with Colorado Medicaid
    - Receive denial or rejection
  - Continue re-filing every 60 days until insurance information is available

Extensions – **Delayed Notification**

- 60 days from eligibility notification date
  - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    - Located in Forms section
    - Complete & retain for record of LBOD
- Bill electronically
  - If paper claim required, submit with copy of Delayed Eligibility Notification Form
- Steps you can take:
  - Review past records
  - Request billing information from member

Extensions – **Backdated Eligibility**

- 120 days from date county enters eligibility into system
- Report by obtaining State-authorized letter identifying:
  - County technician
  - Member name
  - Delayed or backdated
  - Date eligibility was updated

What is the Colorado 1500?

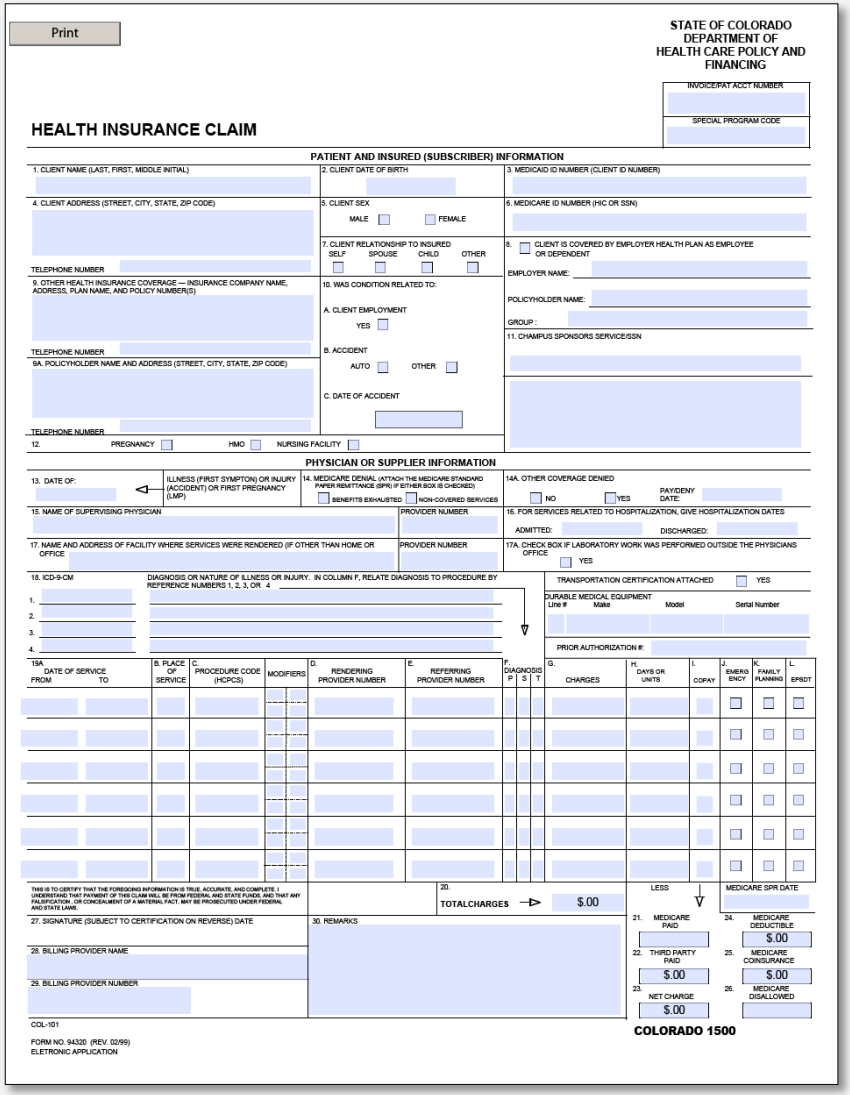
- Colorado specific paper claim form
  - Available in the Provider Services Forms section of the Department's website
  - Print and complete by hand or complete the electronic version online, then print and submit
- Similar to the national CMSa 1500
- The Colorado Medical Assistance Program does not currently accept the CMS 1500
- Any claim submitted on the CMS 1500 will be returned without processing

Colorado 1500

Who completes the Colorado 1500?

HCBS/Waiver providers

Colorado 1500



Print

STATE OF COLORADO
DEPARTMENT OF
HEALTH CARE POLICY AND
FINANCING

INVOICE/PAT ACCT NUMBER

SPECIAL PROGRAM CODE

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL)
2. CLIENT DATE OF BIRTH
3. MEDICAID ID NUMBER (CLIENT ID NUMBER)
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
5. CLIENT SEX — MALE ☐ FEMALE ☐
6. MEDICARE ID NUMBER (HIC OR SSN)
7. CLIENT RELATIONSHIP TO INSURED — SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. ☐ CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT
EMPLOYER NAME:
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)
TELEPHONE NUMBER
10. WAS CONDITION RELATED TO:
A. CLIENT EMPLOYMENT — YES ☐
B. ACCIDENT — AUTO ☐ OTHER ☐
C. DATE OF ACCIDENT
POLICYHOLDER NAME:
GROUP :
11. CHAMPUS SPONSORS SERVICE/SSN
9A. POLICYHOLDER NAME AND ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
12. PREGNANCY ☐ HMO ☐ NURSING FACILITY ☐

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: ILLNESS (FIRST SYMPTON) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)
14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) — BENEFITS EXHAUSTED ☐ NON-COVERED SERVICES ☐
14A. OTHER COVERAGE DENIED — NO ☐ YES ☐ PAY/DENY DATE:
15. NAME OF SUPERVISING PHYSICIAN — PROVIDER NUMBER
16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES — ADMITTED: DISCHARGED:
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE) — PROVIDER NUMBER
17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE ☐ YES
18. ICD-9-CM — DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4
1. 2. 3. 4.
TRANSPORTATION CERTIFICATION ATTACHED ☐ YES
DURABLE MEDICAL EQUIPMENT — Line # Make Model Serial Number
PRIOR AUTHORIZATION #:

19A DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P	S	T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERGENCY	K. FAMILY PLANNING	L. EPSDT
													☐	☐	☐
													☐	☐	☐
													☐	☐	☐
													☐	☐	☐
													☐	☐	☐
													☐	☐	☐

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

20. TOTAL CHARGES $.00

LESS
21. MEDICARE PAID
22. THIRD PARTY PAID $.00
23. NET CHARGE $.00
MEDICARE SPR DATE
24. MEDICARE DEDUCTIBLE $.00
25. MEDICARE COINSURANCE $.00
26. MEDICARE DISALLOWED

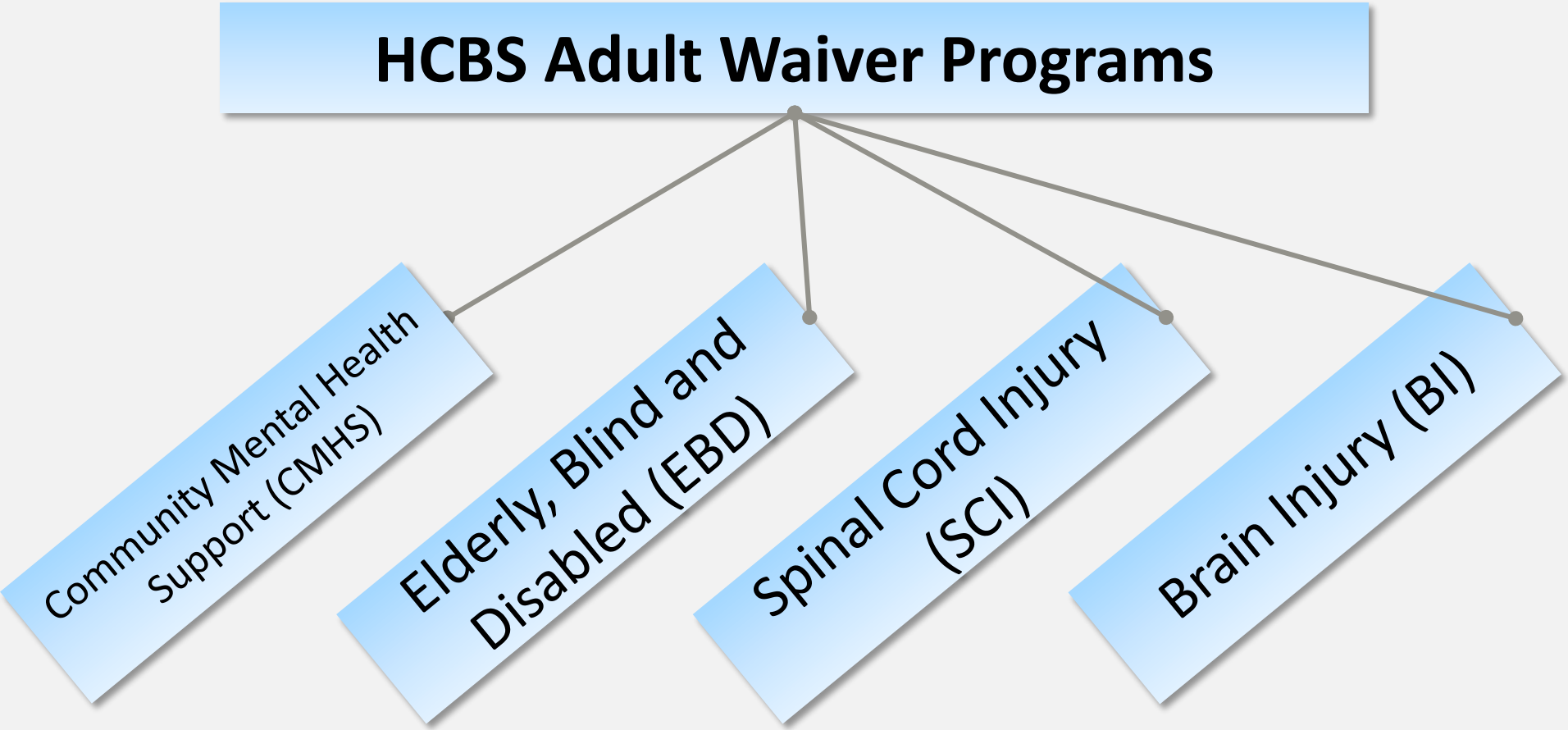
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE
28. BILLING PROVIDER NAME
29. BILLING PROVIDER NUMBER
30. REMARKS

COL-101

FORM NO. 94320 (REV. 02/99)
ELETRONIC APPLICATION

COLORADO 1500

Waiver Programs



Waiver Programs

Special Program Codes

Program	Modifier	Program Code
BI	U6	89
EBD	U1	82
CMHS	UA	94
CCT	UC	95
SCI	SC	M5

HCBS-BI Requirement

- Primary Purpose of Program
  - To provide a home or community based alternative to nursing facility care for persons with a diagnosis of a brain injury
- Members Served
  - Age 16 +
  - Brain injury must have occurred prior to age 65
  - Persons with a brain injury as defined in the Colorado Code of Regulations with specific DSM-IV diagnostic codes
- Level of Care Requirements
  - Nursing Facility and Hospital Level of Care

HCBS-EBD Requirement

- Primary Purpose of Program
  - The EBD program provides home or community based alternative to nursing facility care for elderly, blind, and disabled persons
- Members Served
  - Age 18 +
  - Elderly persons with a functional impairment (aged 65+)
  - Blind or physically disabled persons (aged 18-64)
- Level of Care Requirements
  - Nursing Facility Level of Care

HCBS-CMHS Requirement

- Primary Purpose of Program
  - To provide a home or community based alternative to nursing facility care for persons with a major mental illness
- Members Served
  - Age 18 +
  - Persons with a diagnosis of major mental illness as defined in the Colorado Code of Regulations with specific DSM-IV diagnostic codes
- Level of Care Requirements
  - Nursing Facility Level of Care

HCBS-SCI Requirement

- Primary Purpose of Program
  - To provide a home or community based alternative to nursing facility level of care for persons with a spinal cord injury
- Members Served
  - Age 18+
  - Persons with a spinal cord injury as defined in the Colorado Code of Regulations with specific diagnostic codes
  - Residing in the Denver/Metro area
    - Adams, Arapahoe, Douglas, Denver, Jefferson
- Level of Care Requirements
  - Nursing Facility Level or Hospital Level Care

Consumer Directed Attendant Support Services (CDASS)

- Allows BI, EBD, CMHS, SCI Adult HCBS members to direct their own care
- Delivery option provides the following for Adults:
  - Personal Care
  - Homemaker Services
  - Health Maintenance Activities

In Home Support Services (IHSS)

- Assists CHCBS, EBD & SCI Adult HCBS members in directing their own care through an agency
- Managed by an In-Home Support Services Agency
- IHSS Delivery Option provides the following for Adults:
  - Personal Care
  - Homemaker Services
  - Health Maintenance Activities
- IHSS Delivery Option provides the following for children:
  - Health Maintenance Activities

Colorado Choice Transitions (CCT)

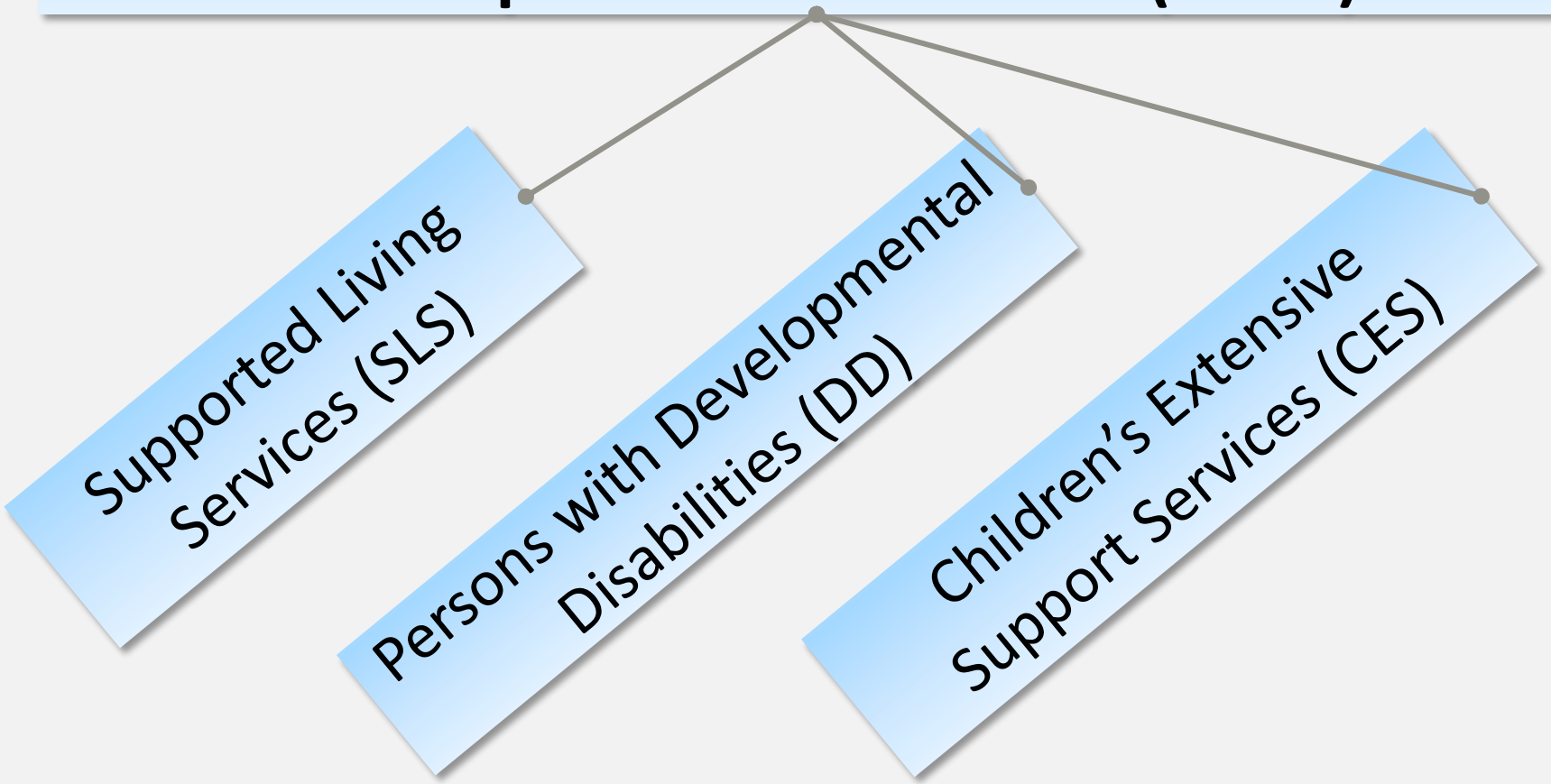
- Helps transition Medicaid members from nursing and other long-term care (LTC) facilities back to the community
  - Participants of the program will have access to:
    - Qualified waiver services
    - Demonstration services

Colorado Choice Transitions (CCT)

- The CCT program compliments the:
  - Elderly, Blind and Disabled Waiver
  - Persons with Brain Injury Waiver
  - Community Mental Health Supports Waiver
  - Persons with Developmental Disabilities Wavier
  - Supported Living Services Waiver
- For more information, please review the HCBS CCT Reference Manual
  - https://www.colorado.gov/hcpf/billing-manuals

Waiver Programs

Division of Intellectual & Developmental Disabilities (DIDD)



Waiver Programs

Special Program Codes

Program	Modifier	Program Code
DD	U3	85
SLS	U8	92
TCM	U4	87
CES	U7	90
CHRP	U9	93

HCBS-DD Requirement

- Primary Purpose of Program
  - Provides persons with developmental disabilities services and support outside family home, allowing them to continue to live in the community
- Members Served
  - Age 18+
  - Persons who are in need of services and supports 24 hours a day that will allow them to live safely and participate in the community
- Level of Care Requirements
  - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

HCBS-SLS Requirement

- Primary Purpose of Program
  - Provides persons with developmental disabilities services and support outside family home, allowing them to continue to live in the community
- Members Served
  - Age 18+
  - Persons who can either live independently with limited supports or who, if they need extensive supports, are already receiving that high level of support from other sources
- Level of Care Requirements
  - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

HCBS-CES Requirement

- Primary Purpose of Program
  - Provides care for children who are at risk of institutionalization have a diagnosis of a Developmental Disability with intense behavioral and/or medical needs
- Members Served
  - Birth through age 17
- Level of Care Requirements
  - Who meet institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)
    - Additional program criteria needed

Waiver Programs

Department of Human Services (DHS)

Children's Habitation Residential Program (CHRP)

Waiver Programs

Special Program Codes

Program	Modifier	Program Code
CHRP	U9	93

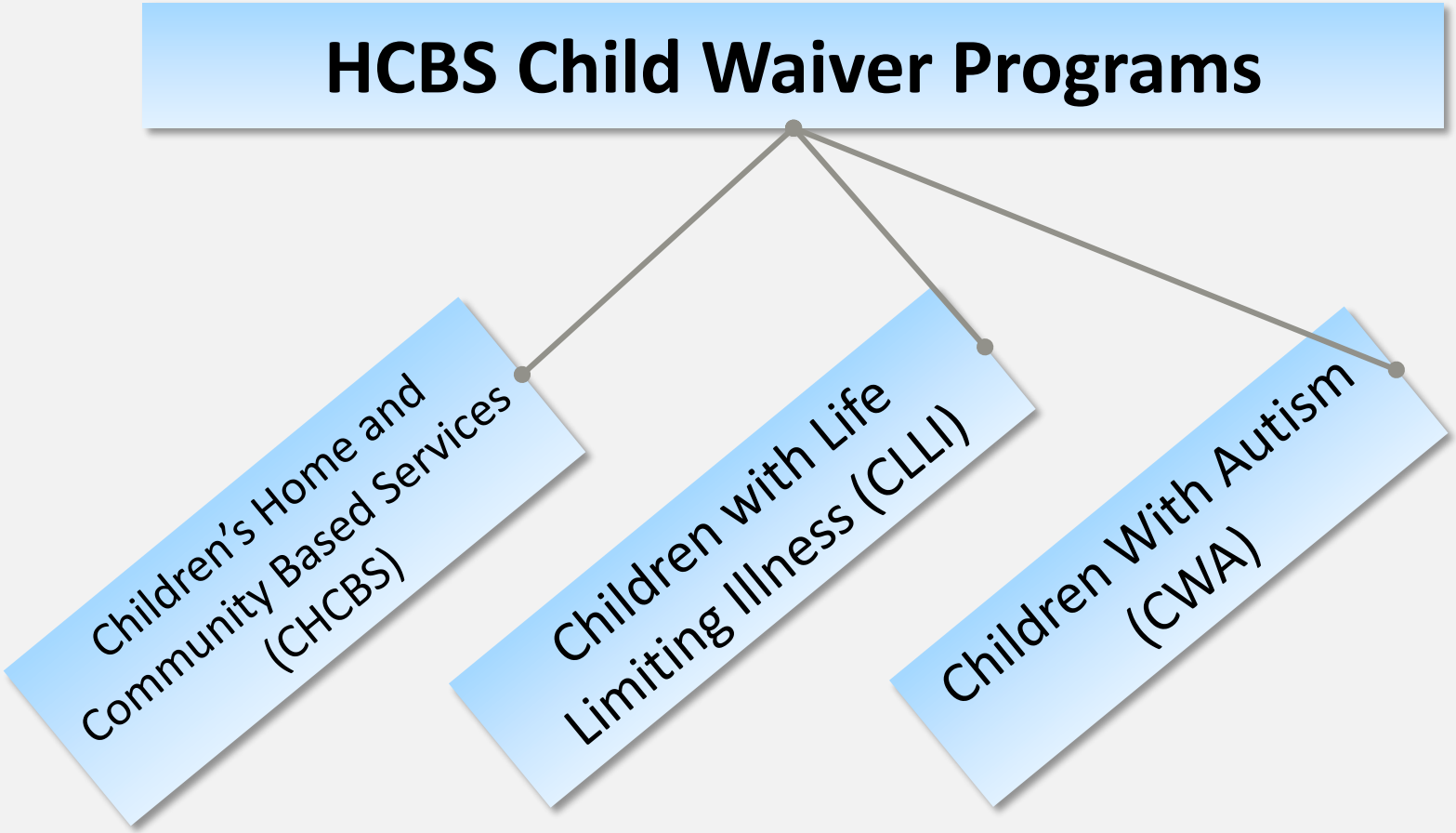
HCBS-CHRP Requirement

- Primary Purpose of Program
  - Provides care for foster children who are at risk of institutionalization and have a diagnosis of a Developmental Disability with extraordinary needs
- Members Served
  - Birth through age 20
- Level of Care Requirements
  - Who meet institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)

Targeted Case Management (TCM)

- TCM is an optional benefit for members enrolled in the following programs
  - HCBS-DD/Comprehensive Waiver
  - HCBS-SLS (Supported Living Services Waiver)
  - HCBS-CES (Children's Extensive Support Waiver)
  - Early Intervention Services (EI)

Waiver Programs



Waiver Programs

Special Program Codes

Program	Modifier	Program Code	Administered By:
CHCBS	U5	88	HCPF
CLLI	UD	97	HCPF
CWA	UL	96	HCPF

HCBS-CHCBS Requirement

- Primary Purpose of Program
  - Provides case management & In-Home support services for children who:
    - Are at risk of institutionalization in a hospital or skilled nursing facility
    - And would not otherwise qualify for Colorado Medical Assistance due to parental income and/or resources
- Members Served
  - Birth through age 17
- Level of Care Requirements
  - Who meet the established minimum criteria for hospital or skilled nursing facility levels of care & who are medically fragile

HCBS-CHCBS Case Management Responsibilities

☐	Inform member and/or guardian(s) of the eligibility process
☐	Arranges for face-to-face contact w/ member within 30 calendar days of receipt of referral
☐	Completes ULTC-100.2
☐	Assesses member's health and social needs
☐	Develops Prior Approval and Cost Containment Record Form of services and projected costs for State approval
☐	Submits a copy of approved Enrollment Form to the County for Colorado Medical Assistance Program State identification number
☐	Monitors and evaluates services
☐	Reassesses each child
☐	Demonstrates continued cost effectiveness, whenever services increase or decrease

HCBS-CLLI Requirement

- Primary Purpose of Program
  - Provides care for children who are at risk of institutionalization in a hospital & have a diagnosis of a life-limiting illness
- Members Served
  - Birth through age 18
- Level of Care Requirements
  - Who meet institutional level of care for inpatient hospitalization

HCBS-CWA Requirement

- Primary Purpose of Program
  - Provides care for children who are at risk of institutionalization and have a medical diagnosis of Autism
- Members Served
  - Birth through age 5
- Level of Care Requirements
  - Who meet institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)

Occurrence Reporting

- Types of Critical Incidents to Report
  - Suspected Abuse, Mistreatment
  - Suspected Neglect
  - Suspected Exploitation
  - All Deaths
  - Serious Illness or Injury
  - Medication Errors
  - Damage or Theft of Member's Property
  - All High Risk Issues
  - All unplanned Hospitalizations

Occurrence Reporting

- HCBS providers who experience a critical incident involving a member enrolled in waiver programs:
  - Are required to report **all** critical incidents to member's case manager within 24 hours of discovery
  - Should also report applicable incidents to appropriate authorities
    - Department of Public Health and Environment
    - Adult or Child Protective Services
    - Local law enforcement

Common Denial Reasons

Timely Filing	Claim was submitted more than 120 days without a LBOD
Duplicate Claim	A subsequent claim was submitted after a claim for the same service has already been paid.
Bill Medicare or Other Insurance	Medicaid is always the "Payor of Last Resort". Provider should bill all other appropriate carriers first
PAR not on file	No approved authorization on file for services that are being submitted
Total Charges invalid	Line item charges do not match the claim total

Claims Process - Common Terms

Reject

Claim has primary data edits – **not** accepted by claims processing system

Denied

Claim processed & denied by claims processing system

Accept

Claim accepted by claims processing system

Paid

Claim processed & paid by claims processing system

Claims Process - Common Terms

Correcting under/overpayments, claims paid at zero & claims history info

Adjustment

Re-bill previously denied claim

Rebill

Claim must be manually reviewed before adjudication

Suspend

"Cancelling" a "paid" claim (wait 48 hours to rebill)

Void

Adjusting Claims

- **What is an adjustment?**
  - Adjustments create a replacement claim
  - Two step process: Credit & Repayment

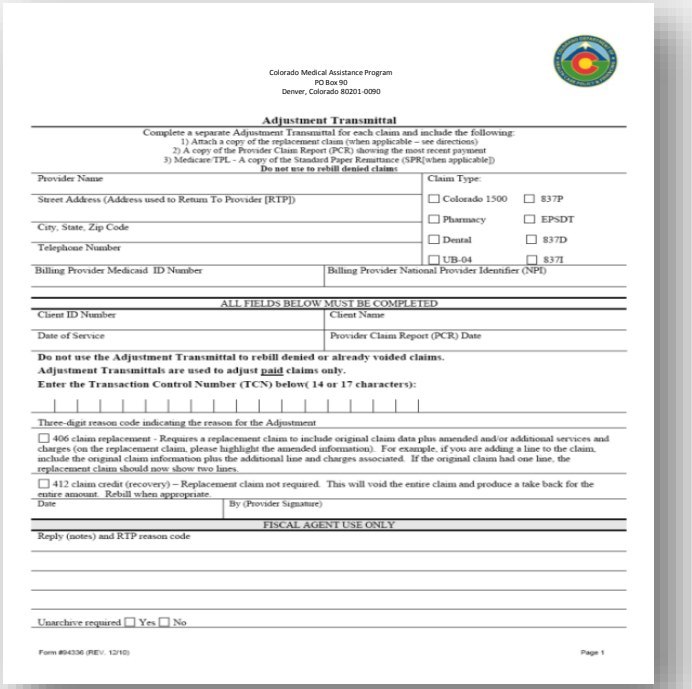
Adjust a claim when:

- Provider billed incorrect services or charges
- Claim paid incorrectly

Do not adjust when:

- Claim was denied
- Claim is in process
- Claim is suspended

Adjustment Methods



Colorado Medical Assistance Program
PO Box 90
Denver, Colorado 80201-0090

Adjustment Transmittal

Complete a separate Adjustment Transmittal for each claim and include the following:
1) Attach a copy of the replacement claim (when applicable – see directions)
2) A copy of the Provider Claim Report (PCR) showing the most recent payment
3) Medicare/TPL - A copy of the Standard Paper Remittance (SPR)(when applicable])
Do not use to rebill denied claims

Provider Name
Street Address (Address used to Return To Provider [RTP])
City, State, Zip Code
Telephone Number
Billing Provider Medicaid ID Number
Billing Provider National Provider Identifier (NPI)

Claim Type:
☐ Colorado 1500 ☐ 837P
☐ Pharmacy ☐ EPSDT
☐ Dental ☐ 837D
☐ UB-04 ☐ 837I

ALL FIELDS BELOW MUST BE COMPLETED

Client ID Number
Client Name
Date of Service
Provider Claim Report (PCR) Date

Do not use the Adjustment Transmittal to rebill denied or already voided claims.
Adjustment Transmittals are used to adjust paid claims only.
Enter the Transaction Control Number (TCN) below(14 or 17 characters):

Three-digit reason code indicating the reason for the Adjustment

☐ 406 claim replacement - Requires a replacement claim to include original claim data plus amended and/or additional services and charges (on the replacement claim, please highlight the amended information). For example, if you are adding a line to the claim, include the original claim information plus the additional line and charges associated. If the original claim had one line, the replacement claim should now show two lines.

☐ 412 claim credit (recovery) – Replacement claim not required. This will void the entire claim and produce a take back for the entire amount. Rebill when appropriate.

Date
By (Provider Signature)

FISCAL AGENT USE ONLY

Reply (notes) and RTP reason code

Unarchive required ☐ Yes ☐ No

Form #04336 (REV. 12/10)
Page 1

Web Portal

- Preferred method
- Easier to submit & track

Paper

- Complete Adjustment Transmittal form
- Be concise & clear

Provider Claim Reports (PCRs)

- Contains the following claims information:
  - Paid
  - Denied
  - Adjusted
  - Voided
  - In process
- Providers required to retrieve PCR through File & Report Service (FRS)
  - Via Web Portal

Provider Claim Reports (PCRs)

- Available through FRS for 60 days
- Two options to obtain duplicate PCRs:
  - Fiscal agent will send encrypted email with copy of PCR attached
    - $2.00/ page
  - Fiscal agent will mail copy of PCR via FedEx
    - Flat rate- $2.61/ page for business address
    - $2.86/ page for residential address
- Charge is assessed regardless of whether request made within 1 month of PCR issue date or not

Provider Claim Reports (PCRs)

Paid

****
* CLAIMS PAID *
****

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	DATES OF SVC TO	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
7015	CLIENT, IMA	Z000000	040800000000000001	040508	040508	132.00	69.46	2.00	0.00	69.46
PROC CODE - MODIFIER 99214 -				040508	040508	132.00	69.46	2.00		

TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE .... TOTAL CLAIMS PAID 1 TOTAL PAYMENTS 69.46

Denied

* CLAIMS DENIED *
****

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SERVICE FROM	DATES OF SERVICE TO	TOTAL DENIED	DENIAL REASONS ERROR CODES
STEDOTCCIOT	CLIENT, IMA	A000000	308000000000000003	03/05/08	03/06/08	245.04	1348

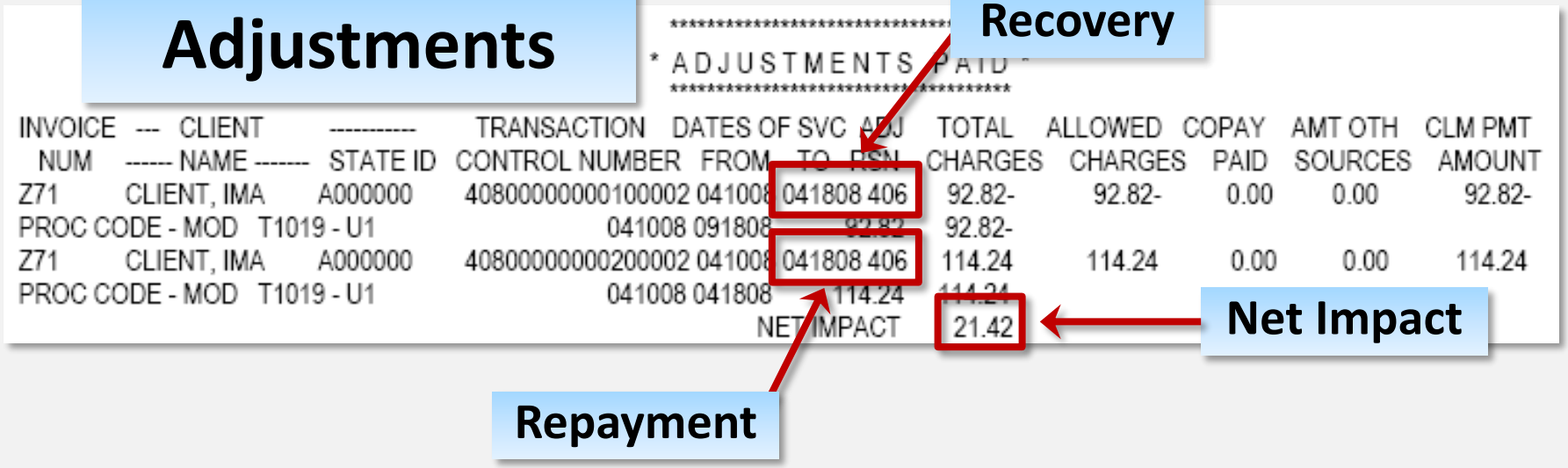
TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE 1

THE FOLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

1348 The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62, '63', '64', or '65 for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'. COUNT 0001

Provider Claim Reports (PCRs)

Adjustments



****
* ADJUSTMENTS PAID *
****

INVOICE NUM	CLIENT ------ NAME -------	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	TO	ADJ RSN	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
Z71	CLIENT, IMA	A000000	40800000000100002	041008	041808	406	92.82-	92.82-	0.00	0.00	92.82-
PROC CODE - MOD T1019 - U1				041008	091808		92.82	92.82-			
Z71	CLIENT, IMA	A000000	40800000000200002	041008	041808	406	114.24	114.24	0.00	0.00	114.24
PROC CODE - MOD T1019 - U1				041008	041808		114.24	114.24			
						NET IMPACT	21.42				

Recovery

Net Impact

Repayment

Voids

****
* ADJUSTMENTS PAID *
****

INVOICE – NUM	CLIENT ------ NAME -------	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	TO	ADJ RSN	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
A83	CLIENT, IMA	Y000002	40800000000100009	040608	042008	212	642.60-	642.60-	0.00	0.00	642.60-
PROC CODE - MOD T1019 - U1				040608	042008		642.60-	642.60-			
						NET IMPACT	642.60-				

Provider Services

Xerox
1-800-237-0757

- Claims/Billing/ Payment
- Forms/Website
- EDI
- Enrolling New Providers
- Updating existing provider profile

CGI
1-888-538-4275

- Email helpdesk.HCG.central.us@cgi.com
- CMAP Web Portal technical support
- CMAP Web Portal Password resets
- CMAP Web Portal End User training

Thank You!